Appendix E: Washington Health Program (WHP) - 2010 Performance Standards

2010 Performance Standards: If CONTRACTOR is contracted to provide Subsidized Basic Health (BH) coverage in 2010, please segregate performance data in accordance to line of business (i.e., subsidized BH, WHP). If segregation is not possible at contract award date, please combine BH and WHP data. **Please note: Segregation of data will be an expectation 2013.**

Performance Standards		Standard Definition
	Claims Quality	
Standard 1	**Financial Payment (Dollar) Accuracy:** **98.5% [If HCA membership (BH and/or WHP) represents more than 25% of Vendor's book of business at the office in which claims are processed, the Vendor is expected to report on WHP specific results by July 1, 2013]**	The percentage of claim dollars paid accurately. Calculated as the total paid dollars minus the absolute value of over- and underpayments, divided by total paid dollars.
Standard 2	**Payment Incidence Accuracy:** **97.0% [If HCA membership (BH and/or WHP) represents more than 25% of Vendor's book of business at the office in which claims are processed, the Vendor is expected to report on WHP specific results by July 1, 2013]**	The percentage of claims processed without payment error. Calculated as the total number of claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of claims. Error is defined as any error, regardless of cause (e.g., coding, procedural, system) that results in an overpayment or an underpayment. Each type of error is counted as one full error but no more than one error can be assigned to one claim.
Standard 3	**Claims Rework:** **Plan will guarantee the percentage of claims requiring rework will be 6.0% or less.** **(book of business)**	Rework is defined as any claim that requires an adjustment to the initial adjudication determination due to an error on the part of the CONTRACTOR (e.g., incorrect plan provision) at the time the claim was processed. Calculated as the number of claims requiring rework divided by the total number of claims.

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	Claims Turnaround Time	
Standard 4	**Percent within 30 calendar days for clean claims and 60 calendar days for all claims:** **Plan will pay 95% of clean claims within 30 calendar days and 98% of all claims (paid or denied) within 60 calendar days. [If HCA membership (BH and/or WHP) represents more than 25% of Vendor's book of business at the office in which claims are processed, the Vendor is expected to report on WHP-specific results by July 1, 2013]**	TAT is measured from the date a claim is received by the administrator (either via paper or electronic data interchange) to the date it is processed for payment or denied.
	Customer Service	
Standard 5	**Call Abandonment Rate:** **≤ 3% (Book of business)**	Percentage of calls that reach the CONTRACTOR and are placed in member services queue, but are not answered because caller hangs up before a customer service representative (CSR) becomes available. Any calls that abandon within 10 seconds of being placed in queue need not be counted. Calculated as the number of calls in member services queue that are abandoned divided by number of calls placed in queue. Note: Calls that are answered by automated responses (e.g., claim status, eligibility) should not be included in measurement (i.e., added to the count of calls that reach facility and are placed in queue).
Standard 6	**Annual Member Satisfaction Survey:** **CONTRACTOR'S performance on Member Satisfaction will meet or exceed the average regional health plan performance based on the CAHPS survey** **60% response rate for Q42 with an 8.9.10 (Book of Business)**	The standard will be based on calendar year 2010 data, to be reported as described in Exhibit 12, Reports.
Standard 7	**Call response time:** **Average speed of answer less than 30 seconds (Book of Business)**	

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	Administration	
Standard 8	**Identification Cards:** **97% of ID cards sent within 15 business days of receipt of eligibility.** **(Specific to WHP membership)**	1. Open Enrollment 97% of ID cards mailed within 15 business days, but not later than two weeks prior to the contract effective date. In order to be counted in this measure, receipt of HCA or Medicaid enrollment must be received by CONTRACTOR 21 business days prior to the contract effective date. 2. On-Going Enrollments (Outside of Open Enrollment) 97% mailed within 15 business days of receipt of confirmation of enrollment from HCA.
Standard 9	**Certificates of Coverage:** **97% of the Certificates of Coverage (COC) mailed within 15 business days of receipt of confirmation of enrollment from the HCA or Medicaid.** **(Specific to WHP membership)**	97% of the Certificates of Coverage (COC) provided within 15 business days of receipt of confirmation of enrollment from the HCA or Medicaid. CONTRACTOR may send the COC electronically under the provisions of Section 2.4.5. of the Contract.
	Additional Information	
Standard 10	**Tracking, monitoring of grievance activity; resolution; provision of summary reports to THE HCA** **(Specific to WHP)**	100% of grievances shall be resolved within 30 calendar days. Appeals resolution process and timeline will be in compliance with the Patient's Bill of Rights. **Appeals:** Appeals will be resolved within 30 days and a summary report provided to THE HCA quarterly
Standard 11	**Plans will request COB information from the member at least once per year, but the Plans will report the outcomes of the COB information requested below twice per year. The Plans will outline data collection methods to the HCA (e.g., letter to member).**	**Plans will provide the following to The HCA for claims paid from January 1, 2010 - June 30, 2010 and July 1, 2010 – December 31, 2010** • **Number of accounts with COB** • **Total COB dollars collected** • **Percent of total accounts with COB**

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II. Schedule of Performance Standard Reporting

	Standard	Reporting Frequency
	Claims Quality	
1	▪ Financial payment (dollar) accuracy	Quarterly
2	▪ Payment incidence accuracy	Quarterly
3	▪ Reduction in rework	Quarterly
	Claims Turnaround Time	
4	▪ Clean claims and all claims	Quarterly
	Customer Service	
5	▪ Call abandonment rate	Semi-Annual
6	▪ Annual member satisfaction survey	Annual
7	▪ Call response time	Semi-Annual
	Administration	
8	▪ Identification card timeliness	Semi-Annual
9	• Certificate of Coverage timeliness	Semi-Annual
10	Grievances & Appeals	Quarterly
11	Coordination of Benefits	Semi-annual

Appendix E: Washington Health Program - 2010 Performance Standards

III. General Performance Standard Provisions

A. General Provisions

- The performance standards shall become effective on the first day of July 2010, unless otherwise specified, and shall remain in effect through December 31, 2011.
- At the close of the 2010 calendar year, these 2010 standards shall automatically renew at that time until December 21, 2011.
- The standards outlined in this document may be revised based on mutual agreement between the Health Care Authority and the CONTRACTOR.
- The CONTRACTOR is responsible for informing the Health Care Authority if it is reporting on book-of-business or client specific per the schedule of standards.
- Results and accuracy shall be measured by CONTRACTOR, for each measurement period and reported to the Health Care Authority, as indicated for each performance standard. The CONTRACTOR shall report performance to the Health Care Authority at least quarterly, except for standards measured on a semi-annual or annual basis as indicated in item II, the Schedule of Performance Reporting. The Health Care Authority reserves the right to request additional documentation of performance.
- At the option and expense of the Health Care Authority, the accuracy of the CONTRACTOR's claims handling accuracy and timeliness performance results may be subject to an independent audit and CONTRACTOR will be provided a minimum of 45 days advance notice of such audit. Any such audit will be conducted consistent with applicable state and federal privacy laws. Preliminary results of any independent audit shall be provided to the CONTRACTOR for review, in order to give the CONTRACTOR the opportunity to address and correct any errors by the independent audit company in interpreting the CONTRACTOR's data or systems. If the results of the independent audit are below the results reported by the CONTRACTOR for the audit period by more than 5%, then the CONTRACTOR agrees that the results of the independent audit will be used as the basis for assessing the annual performance and with respect to potential premiums at risk for this contract period (at risk premium applicable to quality standards only).
- CONTRACTOR shall provide quarterly performance result reports to the Health Care Authority within 30 days following the end of each quarter. Reports must be sent to TBD.
- Performance Standards for the Financial Payment Accuracy, Payment Incidence Accuracy, Reduction in Rework, Claims Turnaround Time and Call Abandonment Rate standards may be rounded to a tenth of a percentage point (e.g., 98.75% becomes 98.8%). No rounding is permitted in the reporting of other standards.
- CONTRACTOR will provide the Health Care Authority with a corrective action plan within one month that addresses below standard performance with its quarterly report. A corrective action plan is required for any standard missed by 1 (one) percentage point or more in one quarter, or by any amount for two consecutive quarters.